

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-1055

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

60 years

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

Katie Adkins

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white

single

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age.....

years

Aug 31-1865

8. AGE:

Years

Months

Days

If less than one day

80

4

20

hrs.

min.

9. Birthplace.....

Town, county, and state)

Salisbury Wicomico Maryland

10. Usual occupation.....

Housekeeper

11. Industry or business

12. Name.....

R. D. Adkins

13. Birthplace.....

Maryland

14. Maiden name.....

Katie Savage

15. Birthplace.....

Virginia

16. Informant.....

Address.....

Mrs. Hartley Stevens

Snow Hill Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Jan. 24, 1946
(month) (day) (year)

Cemetery or crematory..... Presbyterian Cemetery

Location.....

Pocomoke Rd.

18. Funeral director.....

Margaret Adkins

Address.....

Pocomoke Md.

19. Date rec'd by registrar.....

Jan. 23, 1946

Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Maryland

County.....

Worcester

City or town.....

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Market

Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

A. M.

20. DATE OF DEATH..... January 21st, 1946, at 11:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16th, 1946, to 1/21st/1946.

and that I last saw h... alive on January 21st, 1946.

Immediate cause of death..... Physical exhaustion.

DURATION

5 days

Due to..... Cerebral hemorrhage

5 days

Due to..... Arteriosclerosis due to age(?)

Other conditions..... Has been blind for a period of about ten years.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

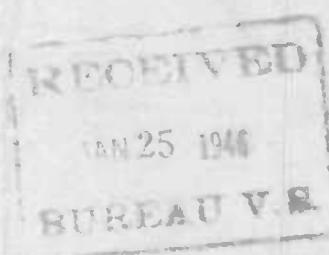
23. SIGNATURE.....

R. Lee Hale

M. D. or other

Baltimore City Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1401

CERTIFICATE OF DEATH

01056 355
Reg. Dist. No.

1. PLACE OF DEATH:

County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

RP-1

How long in hospital or institution?

3. (a) FULL NAME

CHARLES H. BASSETT

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE WHITE SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) AUGUST 24 1863

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

82 5 6.hrs. min.9. Birthplace BERLIN WOR. CO. MD

(Town, county, and state)

10. Usual occupation

FARMER

11. Industry or business

12. Name BENJAMIN BASSETT13. Birthplace MD.14. Maiden name SULLIA ANN BARNES15. Birthplace MD.16. Informant MRS. WILLIAM BASSETT

Address

SALISBURY MD17. Burial Date thereof 2/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EVERGREENLocation BERLIN, MD18. Funeral director Diana A. Burdage

Address

Berlin MD

19. 2-1-

1946

Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. SP 1-1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH JAN 30 1946 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN 25 1946 to JAN 30 1946 and that I last saw h. alive on JAN 30 1946

Immediate cause of death

Pneumonia

DURATION

5 daysDue to Pneumonia30 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

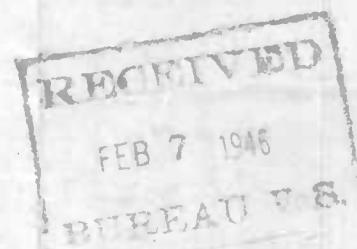
Means of injury

Injured at work?

23. SIGNATURE L. Hayes, M.D.

M. D. or other

Address BerlinDate signed 2/1/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01057

353

Reg. Dist. No.

1. PLACE OF DEATH: Worcester
 County Bushpville

City or town Bushpville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Almina Bunting

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elisha M. Bunting 6. (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Dec 11 1874 6. (c) If alive, give age 77 years

8. AGE: 71 Years 1 Months 20 Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Elisha Bunting

13. Birthplace Md.

14. Maiden name Nancy Bunting

15. Birthplace Md.

16. Informant John Bunting

Address Bishop, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof Dec 29 1946 (month) (day) (year)

Cemetery or crematory J.C.C.

Location Bishopville, Md.

18. Funeral director M. Pasha Watson

Address Selbyville, Del.

19. Date rec'd by registrar Jan 26 1946 Registrar Robert C. Gray

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Bishopville (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war:

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1943 to Jan 24 1946

and that I last saw her alive on Jan. 24 1946

Immediate cause of death Diabetes mellitus, Severe DURATION 3 yrs.

Due to Arterio-sclerotic heart disease DURATION 5 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert C. Gray M. D. or other

Address Frankford Del. Date signed 1-26-46

BT 2381 10-1711A16 STATE GRABER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

01058

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 years

Hospital, institution, or street address where death occurred:

Rt 2

How long in hospital or institution?.....

3. (a) FULL NAME

William Henry Hayward

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Nester York Hayward

6.(c) If alive, give age..... years

March 21, 1878

7. Birth date of

deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

67 10 0 hrs. min.

9. Birthplace

Somerset County - Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

Harry Hayward

13. Birthplace

Somerset County, Md

14. Maiden name

Malinda Miles

15. Birthplace

Somerset County, Md

16. Informant

Malinda Hayward

Address

Pocomoke City, Md #Rt 3

17. Burial

Date thereof Jan. 25 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Waters Private Cemetery

Location

RURAL, Pocomoke City, Md

18. Funeral director

H. Harvey Bradshaw

Address

Pocomoke City, Md.

19. Date rec'd by registrar

Jan. 25, 1946

(Date rec'd by registrar)

Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Somerset

City or town.....

Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Rt 1

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 21 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 to Jan 21 1946

and that I last saw him alive on Jan 19 1946

Immediate cause of death

Off fire in burning house

Proximate cause

Hayocarditis

Duration

1 K

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

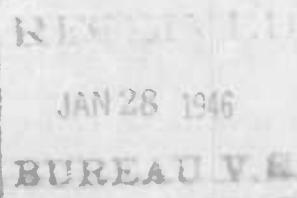
23. SIGNATURE

D. E. Sartoris, M.D.

M. D. or other

Address

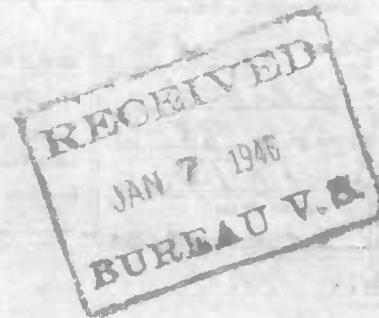
Date signed



BY MAIL TO THE STATE DEPARTMENT

OR BY AIR MAIL TO THE STATE DEPARTMENT

BY AIR MAIL TO THE STATE DEPARTMENT



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48B

01060

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH: Worcester
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION) 70
 2.(a) If veteran, name war.

3. (a) FULL NAME

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elmer M. Mason

7. Birth date of deceased (mo., day, yr.) March 25 1892 8. (c) If alive, give age 65 years

8. AGE: Years 53 Months 9 Days 10 If less than one day hrs. min.

9. Birthplace St. Albans, Worcester, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name John S. Stevens

13. Birthplace Maryland

14. Maiden name Estelle Stevens

15. Birthplace Maryland

16. Informant W. Elmer M. Mason

Address Snow Hill, Md.

17. Funeral Funeral Date thereof Jan 7/46
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Beth Memorial

Location Snow Hill, Md

18. Funeral director Teamie & Dennis

Address Snow Hill, Md

19. 1/7/46 19. 46 (Date rec'd by registrar) Ray Smith Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 19. 46 at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19. 45 to January 5 19. 46
 and that I last saw her alive on January 4 19. 46

Immediate cause of death Anemia & Cachexia DURATION 6 yrs

Due to uterine carcinoma 10 mos

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of (month) (day) (year)

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert La Mar, MD M. D. of other None

Date signed 1-7-46 Address Snow Hill

RECEIVED

JAN 10 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

01061-353

Reg. Dist. No.

1. PLACE OF DEATH:

County Worcester
City or town Whaleyville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Henry Moore

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male colored8. (b) Name of husband or wife Belle Moore7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871 8. (c) If alive, give age years8. AGE: Years 74 Months 4 Days 5 If less than one day
hrs. min.9. Birthplace Md.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

Big Moore13. Birthplace Md.14. Maiden name Jane Townsend
15. Birthplace Md.18. Informant Kate ShowellAddress Berlin, Md.17. Burial Burial Date thereof Jan. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Long Cem.Location Suburb of Del.18. Funeral director Margarette S. WatsonAddress Pocomoke City, Md.19. Date rec'd by registrar Jan. 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester
City or town Whaleyville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16, 1946 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3, 1946 to Jan. 16, 1946 and that I last saw him alive on Jan. 16, 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

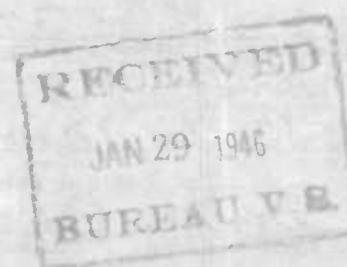
Means of injury.....

Injured at work?

23. SIGNATURE W. E. Thomas

M. D. or other

Address Suburb of Del.Date signed 1-17-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

CERTIFICATE OF DEATH

01062

353

Reg. Dist. No.

1. PLACE OF DEATH:

County..... *worcester*
 City or town..... *near Fairbury Selbyville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Oscar Dewey Mumford

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**Col*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

Aug. 21, 1899

8. AGE:

Years

Months

Days

If less than one day

*46**5**6*

hrs

min.

9. Birthplace.....

(Town, county, and state)

Bishop, Md.

10. Usual occupation.....

Farming

11. Industry or business.....

Isaac Mumford

12. Name.....

13. Birthplace.....

Md.

14. Maiden name.....

Dewey Halland

15. Birthplace.....

Md.

16. Informant.....

Ephraim Mumford

Address

Selbyville Del

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *Jan. 30, 1946*
 (month) (day) (year)

Cemetery or crematory

Sarah Dulan Bishop, Md.

Location.....

Marguerite H. Watson

18. Funeral director.....

*Potomac City, Md.*Address *Jan 30 1946 Meeting House*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *worcester*City or town..... *near Selbyville Del*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 27 1946 at *1* a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

Stab wound of heart

DURATION

5 min

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

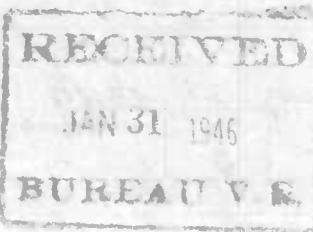
Accident, suicide, or homicide..... *Homicide* Date of..... *Jan 27*Where did injury occur..... *near Selbyville Worcester Md* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Stab wound* Injured at work? *No*

23. SIGNATURE

*John L Riley sub ms Exam*M. D. or other *Browne*Address *1127 1/46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

01063

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH: *Worchester*
 County: *Snow Hill*
 City or town: *Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *42 years*
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Elijah Albert Gerde*4. Sex *Male* 5. Color of race *White* 6. (a) Single, married, widowed, or divorced *Divorced*

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) *March 20 - 1863* 8. (c) If alive, give age years8. AGE: Years *83* Months *9* Days *26* It less than one day *hrs. 00 min.*9. Birthplace *Pittsville Wisconsin* *MD* (Town, county, and state)10. Usual occupation *Retired Merchant*11. Industry or business *Gracy Stage*12. Name *John G. Gerde*13. Birthplace *Maryland*14. Maiden name *Maharet Elly*15. Birthplace *Maryland*16. Informant *Mr. John W. Coffey*Address *Snow Hill, MD*17. Burial Date thereof *Jan. 19/46* (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Worchester*Location *Snow Hill, MD*18. Funeral director *Hearn & Dunnings*Address *Snow Hill, MD*19. (Date rec'd by registrar) *1/8 1946* *Robert L. May, M.D.* *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State *Maryland* County *Worchester*
 City or town *Snow Hill*
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *70*
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number *None*

MEDICAL CERTIFICATION	
20. DATE OF DEATH	<i>January 16 1946</i>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>March 15 1945</i> to <i>January 16 1946</i> and that I last saw him alive on <i>January 8 1946</i>	
Immediate cause of death	<i>acute Salmonella</i> <i>edema</i> <i>Congestive Cardiac Failure</i>
Due to	<i>Hypertensive Cardiovascular</i> <i>Arterial Disease</i>
Other conditions	<i>Semifatty</i>
DURATION <i>1 day</i>	
6 weeks	
5 years	

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

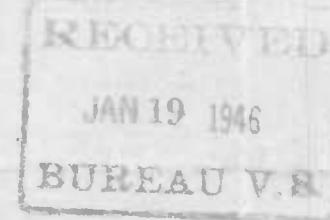
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Robert L. May, M.D.* M. D. or other *Robert L. May, M.D.*Address *Snow Hill* Date signed *1/7/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

CERTIFICATE OF DEATH

01664

Reg. Dist. No. 351

1. PLACE OF DEATH:

County

Worchester

Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

77 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George L. Powell

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife

Betty Powell

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

Feb 24

1866

8. AGE:

Years

Months

Days

If less than one day

79 10 22

hrs.

min.

9. Birthplace

Snow Hill Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER

FATHER

George L. Powell

Snow Hill Md

Charlotte Dryden

Snow Hill Md

Mrs George Powell

16. Informant

Address

Snow Hill Md

Burial

(Burial, cremation, or removal. Which?)

Whitcoat

Location

Snow Hill Md

18. Funeral director

Address

Snow Hill Md

19.

(Date rec'd by registrar)

11/8 1946

LeRoy Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 17 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19. and that I last saw him alive on 19.

Immediate cause of death

Cerebral hemorrhage

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John L. Riley Dep. Reg. Exam.

M. D. or other

Address

Snow Hill Md Date signed 11/17/46

RECEIVED

JAN 19 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

CERTIFICATE OF DEATH

Reg. Dist. No. 350

01065

1. PLACE OF DEATH:

County

City or town

Worcester

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

—

3. (a) FULL NAME

Nancy Faiss

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Widowed

6. (b) Name of husband or wife

Robert Faiss

7. Birth date of

deceased (mo., day, yr.)

Unknown

6. (c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

— hrs. — min.

9. Birthplace

Dorchester

Dorchester Md

(Town, county, and state)

Unknown

10. Usual occupation

Housewife

11. Industry or business

Unknown

FATHER

12. Name

Unknown

13. Birthplace

" "

MOTHER

14. Maiden name

Unknown

15. Birthplace

" "

16. Informant

Samuel Benson

Son

Date

Benson

Pocomoke Md

Address

Unknown

17. Burial

Date thereof

Jan 13 1944

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

Halls Field Cemetery

Pocomoke

18. Funeral director

Margarette Watson

Pocomoke Md

Address

Unknown

19. Date

Jan 15 1944

1944

(Date rec'd by registrar)

Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Pocomoke

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 9 1944 at 3:56 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Open 3rd 1944 to 1944

and that I last saw her alive on Jan 6th 1944

Immediate cause of death

Sudden

Due to

Due to

Other conditions

Myocarditis

Fibrillation of heart

Due to

Sudden

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

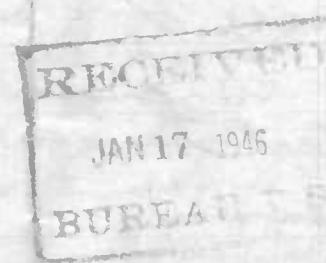
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-6

CERTIFICATE OF DEATH

01066

Reg. Dist. No. 350

1. PLACE OF DEATH: Worcester

County

Pocomoke City

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Leinen

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

maleColoredmarried

8.(b) Name of husband or wife

Waney Leinen9.(c) If alive, give age 82 years

7. Birth date of

deceased (mo., day, yr.)

Unknown1861

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Pocomoke City

(Town, county, and state)

10. Usual occupation

Labour

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

11

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Samuel Penstone

Address

Pocomoke Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Date

Jan 6-1946

(month) (day) (year)

Cemetery or crematory

St. Mary's County

Location

Rural Pocomoke Md.

18. Funeral director

Margarette Leinen

Address

Pocomoke City Md.

19. Date rec'd by registrar

Jan 5, 1946

Date

Signed

Date

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Worcester

City or town

County

Pocomoke City

Street No.

—

—

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1

1946, at 1 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h... alive on

19...

Immediate cause of death

Myocardial degeneration of heart

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

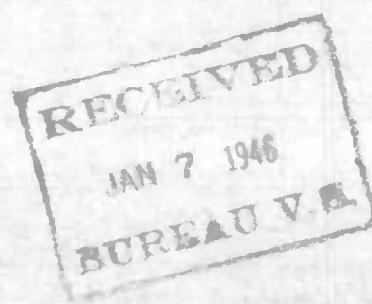
Injured at work?

23. SIGNATURE

M. D. or other

Address

Snow Hill Md.Date signed 1/2/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B.M.*

01067

CERTIFICATE OF DEATH

Reg. Diet. No. 355

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

80 years

Hospital, Institution, or street address where death occurred:

8

How long in hospital or institution?

3. (a) FULL NAME

Martha Hester Payne.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife.....

Parker S. Payne.

7. Birth date of deceased (mo., day, yr.)

June 29, 1863

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

82 6 21 hrs. min.

9. Birthplace.....

Berlin Wor. C. Md. P.T.D.

(Town, County, and state)

10. Usual occupation.....

Housewife.

11. Industry or business

FATHER

12. Name..... Stephen Hadden

13. Birthplace

Maryland

MOTHER

14. Maiden name..... Rebecca Reed

15. Birthplace

Maryland.

16. Informant.....

Mrs. John Townsend

Address

Berlin Md. P.T.D.

17. Burial

Date thereof..... 1/23/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Riverside

Location.....

Berlin Md. P.T.D.

18. Funeral director.....

Dame R. Bimberg

Address

Berlin Md.

19. 1-23

(Date rec'd by registrar)

1946 Helen S. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Worcester

City or town.....

Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 20 1946 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19

and that I last saw h..... alive on

19

Immediate cause of death.....

Chr. Diphilis

Due to.....

Due to.....

Chr. Myocarditis

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

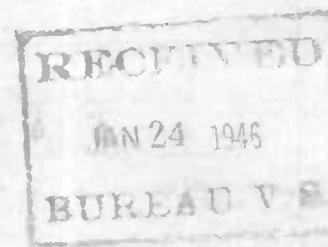
Means of injury.....

Injured at work?

23. SIGNATURE.....

Chas. R. Law, M.D. or other

Address..... Berlin Md. Date signed 1-21-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

01068

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County

Worcester

City or town

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

73 years

Hospital, institution, or street address where death occurred:



How long in hospital or institution?



3. (a) FULL NAME

James S. Roberts

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Widowed

6. (b) Name of husband or wife

Sarah J. Robert

7. Birth date of deceased (mo., day, yr.)

Feb 10, 1851

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Atlantic, Wicomico, Virginia

(Town, county, and state)

Labor

10. Usual occupation

William Roberts

11. Industry or business

Virginia

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

14. Maiden name

Hannah Dickerson

15. Birthplace

Pocomoke, Md.

16. Informant

Burial

Date thereof

(month) (day) (year)

Feb 3 1946

17. (Burial, cremation, or removal. Which?)

Halls Hill Cemetery

Cemetery or crematory

Location

Rural Pocomoke, Md.

18. Funeral director

Marguerite L. Dawson

Address

Pocomoke, Md.

19. Feb 4

1946

Anne E. White

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Worcester

City or town

Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 31 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: That attended deceased from

January 31, 1946, to Jan 30, 1946

and that I last saw him alive on Jan 29, 1946

Immediate cause of death

Henry Tiga

Due to

Central University

Due to

Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

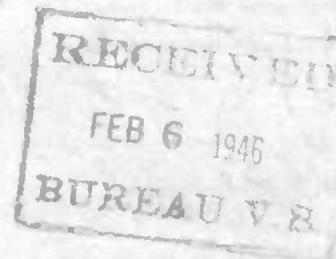
J. J. Partin

M. D. or other

Address

Pocomoke, Md.

Date signed



PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BC*

CERTIFICATE OF DEATH

01069

Reg. Dist. No. 350

1. PLACE OF DEATH:

County..... *Worcester*
 City or town..... *near Pocomoke City*
 (If outside city or town limits, write RURAL and give nearest town) *40 years*

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James D. Small

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*male**white**married*

B. (b) Name of husband or wife.....

Archie Small

7. Birth date of

deceased (mo., day, yr.)

Nov 7, 1868

6.(c) If alive, give age

78

years

8. AGE:

Years	Months	Days	If less than one day
77	2	12	hrs. min.

9. Birthplace

Wassillie Avenue 8a.

(Town, county, and state)

10. Usual occupation

Harrowing

11. Industry or business

Wassillie Small

12. Name.....

Virginia

13. Birthplace

Sally Small

14. Maiden name.....

Virginia

15. Birthplace

Robley Small

16. Informant

Pocomoke Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof..... *Jan 21, 1946*

(month) (day) (year)

Cemetery or crematory

Hall Hill Cemetery

Location

Pocomoke Md.

18. Funeral director

Margaret Watson

Address

*Pocomoke Md.*19. *Jan 21*19. *Mo. Anne E. White*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Worcester*
 City or town..... *near Pocomoke City*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Jan 19 1946* 19..... at..... *(Signature)* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... *Asphyxiation by coal**gas*Due to..... *Escaping from stove*DURATION..... *(Signature)* P

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

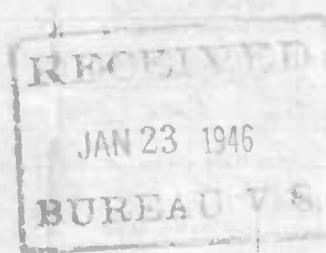
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *John L. Riley* M. D. or other.....Address..... *Short St. 101* Date signed..... *1/19/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01070

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Berlin, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, Institution, or street address where death occurred:.....

no

How long in hospital or institution?.....

no

3. (a) FULL NAME

Mira E. Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female a. a. Single

B. (b) Name of husband or wife.....

no

7. Birth date of deceased (mo., day, yr.)

about

6. (c) If alive, give age.....

no

years

8. AGE:

Years Months Days If less than one day

about 46

—

—

—

hrs.

min.

9. Birthplace.....

Berlin, Md

(Town, county, and state)

10. Usual occupation.....

Housekeeper

11. Industry or business.....

Same as above

FATHER

12. Name.....

Harry Smith

13. Birthplace.....

Berlin, Md

(Town, county, and state)

14. Maiden name.....

Sarah Marshall

15. Birthplace.....

Berlin, Md

(Town, county, and state)

16. Informant.....

Ernest Smith

Address.....

Berlin, Md

17. Burial.....

Date thereof: Jan 29, 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Evergreen

Location.....

Berlin, Md

18. Funeral director.....

James H. Stewart

Address.....

Salisbury, Md

19. I.....

28

1946

(Date rec'd by registrar)

A. (Date of death)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Worcester

City or town.....

Berlin

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

no

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24, 1946, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12, 1946, to Jan 24, 1946

and that I last saw her alive on Jan 23, 1946

Immediate cause of death.....

Intestinal Obstruction

DURATION

2 weeks

Due to: Adhesions. Cancer.

Not due to cancer.

Due to:.....

Other conditions:.....

(Include pregnancy within 3 months of death)

Major findings of operations:.....

Date of op.

Autopsy results:.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE: Clifford E. Schell

M. D. or other

Address: Berlin, Md Date signed: Jan 28, 1946

RECEIVED

JAN 30 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01071
351

Reg. Diat. No.

1. PLACE OF DEATH: Worcester
 County.....
 City or town..... Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME John W. Taylor

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 3 - 1860 8. (c) If alive, give age..... years

8. AGE: Years 85 Months 7 Days 1 If less than one day

9. Birthplace Snow Hill, Worcester, Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business On Farm

12. Name James Taylor

13. Birthplace Virginia

14. Maiden name Unknown

15. Birthplace Worcester

16. Informant Mr. Willie Dickey

Address Poplar Bluff, Mo Rural #3

17. Burial Date thereof Jan. 13, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bates Cemetery

Location Snow Hill, Md

18. Funeral director George J. Dennis

Address Snow Hill, Md

19. (Date read by registrar) 1/12/86 1986 LeRoy Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 30
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946 at 2:45 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 1945 to Jan 9 1946 1946 and that I last saw him alive on Jan 9 1946 1946

Immediate cause of death Congestive Cardiac Failure
COPD
 Due to Pneumonia Labors
 Due to Obstruction
 Other conditions None
 (Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Robert L. La May, M.D. M. D. or other

Address Snow Hill Date signed 1-12-46

